Child's Name:_____ **Date of Birth:**_____

Diagnosis:_____

Allergies:_____

Medications:_____

Today's Date:_____ **Form Completed By:**_____

Please answer the following questions about your child's health and development so we can help with your needs.

Staff Only ***F/U***	**Staying Healthy** **Medical Home:**_____	**YES**	**SOME -TIMES**	**NO**
	1. Do you have a medical home (family doctor or clinic) that you go to when your child is sick or needs a check-up?			
	2. Does your child have regular check-ups with the medical home provider?			
	3. Are your child's immunizations up-to-date?			
	4. Are you happy with your child's weight?			
	5. Does your child sleep well at night?			
	6. Do you or your child brush his/her teeth at least daily?			
	7. Does your child have a check-up with a dentist every year?			
	8. Does your child have a soft-formed bowel movement on a regular basis? (usually every other day)			
	9. Do you regularly fasten your child into a car seat?			
	10. Do you understand the dangers of second-hand smoke to children?			

Name:_____ID #:_____

Staff Only ***F/U***	**Managing Your Child's Healthcare** **Drugstore:_____**	**YES**	**SOME -TIMES**	**NO**
	11. Do you understand your child's health problems?			
	12. Do you participate in your child's treatment? (medications, exercises, therapy)			
	13. Are you being taught how to do your child's treatments?			
	14. Are you continuing your child's treatments at home when the healthcare providers aren't present?			
	15. Do you feel that your child's identified needs are being met?			
	16. Do you know when, how much, and why your child gets medications? (prescription and over-the-counter, like *Tylenol*)			
	17. Do you know the side effects of your child's medications?			
	18. Are you able to get the medications, supplies, and/or equipment your child needs?			
	19. Are you able to pay for your child's dental care?			
	20. Do you know how to use your insurance and/or medical card?			

Name:_____ID #:_____

Staff Only ***F/U***	**Becoming Independent**	**YES**	**SOME -TIMES**	**NO**
	21. Is your child learning to do self-care activities? (feeding self, brushing teeth, bathing)			
	22. Is your child learning to do his/her share of family chores? (picking up toys)			
	23. Is your child responsible for his/her own toileting routine?			
	24. Does your child help himself/herself to get dressed?			
Staff Only ***F/U***	**Interacting with Others**	**YES**	**SOME -TIMES**	**NO**
	25. Is your child able to communicate with others?			
	26. Have you begun to think about your child's future?			
	27. Do you and your child get to have some fun together every day? (playing games, telling stories)			
	28. Does your child spend time outside of your home during the week? (going with you on errands, meeting new people)			
	29. Does your child spend time with other children each week?			
	30. Do you have time to take care of some of your own needs?			

Name:_____ID #:_____

Staff Only ***F/U***	**Children's Rehabilitation Service Satisfaction**	**YES**	**SOME -TIMES**	**NO**
	31. Are you pleased with the care you receive at CRS?			
What would you like to see done differently:				

Information You Would Like to Have:

- ❍ Growth & Development
- ❍ Health Information
- ❍ Education
- ❍ Medicaid
- ❍ Assistance Programs
- ❍ Counseling
- ❍ Social Security
- ❍ Transportation
- ❍ Other:_____

Your Comments:

STAFF USE ONLY:_____

Reviewed By:

Initials	Signature	Date

Name:_____ ID #: _____